STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	293981	A. BUILDING _____ B. WING _____	02/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSHING GEN HOSP & NH PHY CTR	850 SIXTH STREET/PO BOX 661 LOVELOCK, NV 89419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
J 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare recertification survey conducted in your facility on 2/10/09. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following Condition of Coverage was not met: 42 CFR 491.11 Program Evaluation	J 000		
J 076	491.11 PROGRAM EVALUATION An adequate program evaluation has been completed. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate that an annual evaluation of the program met all of the criteria required in 42 CFR 491.11. Findings include: A review of the facility's policy and procedure manual failed to reveal evidence of review or revision since 2007. An interview with the clinic manager revealed the manual had not been reviewed in the last year. A review of the monthly medical staff meeting minutes over the last year failed to reveal evidence of a peer review of sampled medical records, nor evidence of a review of, or changes, to the facility's policies, utilization of services, or evidence of evaluation of service volume.	J 076		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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J 076	Continued From page 1 The clinic manager revealed that evidence of such a comprehensive evaluation of the program was not available.	J 076		